

RESPONSE MODE <input type="checkbox"/> 1. Non-Emergent <input type="checkbox"/> 2. Emergent		TYPE OF RESPONSE DELAY <input type="checkbox"/> 1. None <input type="checkbox"/> 4. Distance <input type="checkbox"/> 7. Safety <input type="checkbox"/> 10. Vehicle Crash <input type="checkbox"/> 2. Crowd <input type="checkbox"/> 5. Diversion <input type="checkbox"/> 8. Staff Delay <input type="checkbox"/> 11. Vehicle Failure <input type="checkbox"/> 3. Directions <input type="checkbox"/> 6. HazMat <input type="checkbox"/> 9. Traffic <input type="checkbox"/> 12. Weather <input type="checkbox"/> 13. Other				ONSET OF SYMPTOMS - ELAPSED TIME (chest pain and stroke only) Hr. Min. <div style="border: 1px solid black; width: 40px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> : <div style="border: 1px solid black; width: 40px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div>		TIME EXTRICATION COMPLETED Hr. Min. <div style="border: 1px solid black; width: 40px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div> : <div style="border: 1px solid black; width: 40px; height: 30px; display: flex; align-items: center; justify-content: center;"> </div>																								
PROCEDURES	<input type="checkbox"/> 0. None <input type="checkbox"/> 6. ECG Monitor <input type="checkbox"/> 29. Epipen Used		Alerts/Instructions Left w/Patient <input type="checkbox"/> 33. <u>Low</u> Blood Sugar <input type="checkbox"/> 34. <u>High</u> Blood Sugar <input type="checkbox"/> 35. High <u>Blood Pressure</u>		Procedure EMS Number																											
	<input type="checkbox"/> 1. Oxygen <input type="checkbox"/> 7. C-Collar/Backboard				<table border="1" style="width: 100%; text-align: center;"> <tr> <td style="font-size: 1.5em; font-weight: bold;">1</td> <td style="font-size: 1.5em; font-weight: bold;">5</td> <td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td style="font-size: 1.5em; font-weight: bold;">2</td> <td style="font-size: 1.5em; font-weight: bold;">1</td> <td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td style="font-size: 1.5em; font-weight: bold;">2</td> <td style="font-size: 1.5em; font-weight: bold;">5</td> <td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>				1	5							2	1							2	5						
	1	5																														
	2	1																														
2	5																															
<input type="checkbox"/> 2. Wound Care <input type="checkbox"/> 8. CPR																																
<input type="checkbox"/> 3. Extrication/Rescue <input type="checkbox"/> 15. Man. DC Shock by EMT																																
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<input type="checkbox"/> 5. Bag Mask <input type="checkbox"/> 25. AED Attached/No Shock																																

CARDIAC ARREST	CPR INITIATED BY		Arrest After Arrival of EMS Personnel?	AED/PAD Used <input type="checkbox"/> 1. Citizen - no shock <input type="checkbox"/> 2. Citizen - shock <input type="checkbox"/> 3. First Responder - no shock <input type="checkbox"/> 4. First Responder - shock	INITIAL RHYTHM	PATIENT OUTCOME (if known)
	<input type="checkbox"/> 1. First Responder / Police <input type="checkbox"/> 2. Fire Dept. (BLS) <input type="checkbox"/> 3. Paramedic (ALS) <input type="checkbox"/> 4. Ambulance	<input type="checkbox"/> 5. MD / RN <input type="checkbox"/> 6. Citizen with Dispatch Assistance <input type="checkbox"/> 7. Citizen without Dispatch Assistance <input type="checkbox"/> 8. CPR Not Attempted	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No	Was Cardiac Arrest Witnessed? <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 3. Unk	ESTIMATED ELAPSED TIME (MIN.) FROM - Collapse to Call Collapse to CPR <div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 40px; height: 40px; position: relative;"> <div style="position: absolute; top: 0; left: 0; right: 0; border-bottom: 1px solid black;"></div> <div style="position: absolute; bottom: 0; left: 0; right: 0; border-top: 1px solid black;"></div> </div> <div style="border: 1px solid black; width: 40px; height: 40px; position: relative;"> <div style="position: absolute; top: 0; left: 0; right: 0; border-bottom: 1px solid black;"></div> <div style="position: absolute; bottom: 0; left: 0; right: 0; border-top: 1px solid black;"></div> </div> </div>	<input type="checkbox"/> 2. V Fib <input type="checkbox"/> 4. Asystole <input type="checkbox"/> 7. Other <input type="checkbox"/> 8. Unknown

EMS Personnel	EMS Number					

EMS Personnel	EMS Number					

Agency Use:

FLOW CHART	TIME → 								Notes		SPHERE	
	Blood Pressure											Hypertension
	Pulse Rate										<input type="checkbox"/> Hx	
	Respiratory Rate										<input type="checkbox"/> Alert Left	
	ECG Rhythm										Diabetes	
	Oxygen										<input type="checkbox"/> Hx	
	Pulse Oximetry										<input type="checkbox"/> Alert Left	
	Glucometry										CONFIRM	
	DC Shock										<input type="checkbox"/> Address	
											<input type="checkbox"/> Phone #	

[illegible]

AGENCY COPY



Refusal of Medical Evaluation, Treatment and/or Transportation

“I hereby acknowledge that I have been advised by emergency medical personnel that evaluation, treatment and/or transportation are necessary for my condition. I have also been informed that I risk medical consequences if I refuse to be examined, treated and/or transported by emergency medical personnel. I hereby state my refusal to follow this advice and refuse further evaluation, treatment and/or transportation to a medical facility.”

Patient’s Name: _____ Date: _____

Patient’s Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

EMT or Paramedic Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Witness EMS Agency Affiliation or Address: _____

Instructions for EMS Personnel

- 1) Complete this form in ink.
- 2) Fill in patient’s name, and the date.
- 3) Read the statement slowly and clearly to the patient. Ask if they understand what it says.
- 4) Have the patient sign on the “Patient Signature” line, or on the “Parent/Guardian” line if appropriate. If the patient or parent/guardian refuses to sign, or you are unable to obtain a signature for any other reason, simply make a note to that effect, sign the form and have it witnessed.
- 5) Obtain a signature from a witness (preferably someone from your agency), and note that person’s EMS agency affiliation or address.



KING COUNTY — BLS INCIDENT REPORT FORM

KING COUNTY — BLS INCIDENT REPORT FORM																									
DATE (MM/DD/YY)						AGENCY INCIDENT NUMBER						Reporting Agency Name										NO.			
<div><div></div><div></div><div></div><div></div><div></div><div></div></div>						<div><div></div><div></div><div></div><div></div><div></div><div></div></div>						<div></div>										<div><div></div><div></div></div>			
Are you First EMS Reporting Agency On The Scene?						<input type="checkbox"/> 1. Yes		<input type="checkbox"/> 2. No		Incident Site						City									
Patient Name (Last, First, Middle Init.)						Mo.		DOB Day		Yr.		Yrs.		AGE		Mo.		Gender							
														<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unk											
Patient Address						City & State						Phone				Geocode		MCI							
																<div><div></div><div></div></div>		<input type="checkbox"/> Yes <input type="checkbox"/> No							
Nearest Relative Name						Relation						Phone				Resp. in FD		Pt. #		Out Of					
																<div><div></div><div></div></div>		<div><div></div><div></div></div>		<div><div></div><div></div></div>					
Patient Healthcare Provider										Phone										1st Unit on Scene				Resp. from QTRs?	
																				<div><div></div><div></div></div>				<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No	
ACTION TAKEN										<input type="checkbox"/> 4. Patient Refused Treatment				Mechanism		INITIAL DISPATCH CODE				Reporting BLS Unit				<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No	
<input type="checkbox"/> 1. Exam Only										<input type="checkbox"/> 5. Service Aid/Patient Assist															
<input type="checkbox"/> 2. Exam & Assist										<input type="checkbox"/> 6. Cancelled				Type		<div></div>				Reporting ALS Unit					
<input type="checkbox"/> 3. No Exam Needed										<input type="checkbox"/> 7. No Patient Found															
Name of Medical Facility Contacted										LOCATION TYPE										<input type="checkbox"/> 7. Nursing Home <input type="checkbox"/> 11. Public Building					
Name of Medical Person Contacted										<input type="checkbox"/> 1. Home Residence <input type="checkbox"/> 4. Industrial <input type="checkbox"/> 8. Medical Facility <input type="checkbox"/> 12. Educational Institution										<input type="checkbox"/> 13. Other Location					
										<input type="checkbox"/> 2. Farm <input type="checkbox"/> 5. Recreation/Sport <input type="checkbox"/> 9. Street <input type="checkbox"/> 10. Highway										<input type="checkbox"/> 99. Unknown					
										<input type="checkbox"/> 3. Mine/Quarry <input type="checkbox"/> 6. Adult Fam. Home															
RESPONSE MODE		TYPE OF RESPONSE DELAY								ONSET OF SYMPTOMS - ELAPSED TIME (chest pain and stroke only)								TIME EXTRICATION COMPLETED							
<input type="checkbox"/> 1. Non-Emergent		<input type="checkbox"/> 1. None <input type="checkbox"/> 4. Distance <input type="checkbox"/> 7. Safety <input type="checkbox"/> 10. Vehicle Crash								<div><div></div><div></div></div> Hr. <div><div></div><div></div></div> Min.								<div><div></div><div></div></div> Hr. <div><div></div><div></div></div> Min.							
<input type="checkbox"/> 2. Emergent		<input type="checkbox"/> 2. Crowd <input type="checkbox"/> 5. Diversion <input type="checkbox"/> 8. Staff Delay <input type="checkbox"/> 11. Vehicle Failure																							
		<input type="checkbox"/> 3. Directions <input type="checkbox"/> 6. HazMat <input type="checkbox"/> 9. Traffic <input type="checkbox"/> 12. Weather <input type="checkbox"/> 13. Other																							
PROCEDURES		<input type="checkbox"/> 0. None		<input type="checkbox"/> 6. ECG Monitor				<input type="checkbox"/> 29. Epipen Used						Procedure				EMS Number							
		<input type="checkbox"/> 1. Oxygen		<input type="checkbox"/> 7. C-Collar/Backboard				Alerts/Instructions Left w/Patient						<div><div>1</div><div>5</div></div>				<div><div></div><div></div></div>							
		<input type="checkbox"/> 2. Wound Care		<input type="checkbox"/> 8. CPR				<input type="checkbox"/> 33. <u>Low</u> Blood Sugar						<div><div>2</div><div>1</div></div>				<div><div></div><div></div></div>							
		<input type="checkbox"/> 3. Extrication/Rescue		<input type="checkbox"/> 15. Man. DC Shock by EMT				<input type="checkbox"/> 34. <u>High</u> Blood Sugar						<div><div>2</div><div>5</div></div>				<div><div></div><div></div></div>							
		<input type="checkbox"/> 4. Splinting		<input type="checkbox"/> 21. Auto. DC Shock by EMT				<input type="checkbox"/> 35. High <u>Blood Pressure</u>																	
		<input type="checkbox"/> 5. Bag Mask		<input type="checkbox"/> 25. AED Attached/No Shock																					
TIME DISPATCH NOTIFIED		TIME UNIT NOTIFIED BY DISPATCH		TIME UNIT RESPONDED		TIME ARRIVED ON SCENE		TIME ARRIVED PATIENT'S SIDE		TIME PATIENT LEFT SCENE		ARRIVED AT TREATMENT FACILITY		IN SERVICE											
<div><div></div><div></div><div></div></div>		<div><div></div><div></div><div></div></div>		<div><div></div><div></div><div></div></div>		<div><div></div><div></div><div></div></div>		<div><div></div><div></div><div></div></div>		<div><div></div><div></div><div></div></div>		<div><div></div><div></div><div></div></div>		<div><div></div><div></div><div></div><div></div><div></div><div></div></div>											
CARDIAC ARREST		CPR INITIATED BY						Arrest After Arrival of EMS Personnel?		AED/PAD Used				INITIAL RHYTHM		PATIENT OUTCOME (if known)									
		<input type="checkbox"/> 1. First Responder / Police <input type="checkbox"/> 5. MD / RN						<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No		<input type="checkbox"/> 1. Citizen - no shock <input type="checkbox"/> 2. Citizen - shock <input type="checkbox"/> 3. First Responder - no shock <input type="checkbox"/> 4. First Responder - shock				<input type="checkbox"/> 2. V Fib		<input type="checkbox"/> 1. DOA <input type="checkbox"/> 2. Expired at scene									
		<input type="checkbox"/> 2. Fire Dept. (BLS) <input type="checkbox"/> 6. Citizen with Dispatch Assistance						Was Cardiac Arrest Witnessed?		ESTIMATED ELAPSED TIME (MIN.) FROM - Collapse to Call Collapse to CPR				<input type="checkbox"/> 4. Asystole		<input type="checkbox"/> 3. Admitted to ER <input type="checkbox"/> 4. Expired at ER									
		<input type="checkbox"/> 3. Paramedic (ALS) <input type="checkbox"/> 7. Citizen without Dispatch Assistance												<input type="checkbox"/> 7. Other		<input type="checkbox"/> 5. Admitted to Hospital									
		<input type="checkbox"/> 4. Ambulance <input type="checkbox"/> 8. CPR Not Attempted						<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 3. Unk						<input type="checkbox"/> 8. Unknown		<input type="checkbox"/> 6. Unknown									
Transport Agency Number				Transport Destination								TYPE OF TRANSPORT DELAY													
<div><div></div><div></div><div></div></div>				<div><div></div><div></div></div>								<input type="checkbox"/> 1. None <input type="checkbox"/> 4. Distance <input type="checkbox"/> 7. Safety <input type="checkbox"/> 10. Vehicle Crash <input type="checkbox"/> 2. Crowd <input type="checkbox"/> 5. Diversion <input type="checkbox"/> 8. Staff Delay <input type="checkbox"/> 11. Vehicle Failure <input type="checkbox"/> 3. Directions <input type="checkbox"/> 6. HazMat <input type="checkbox"/> 9. Traffic <input type="checkbox"/> 12. Weather <input type="checkbox"/> 13. Other													
EMS Personnel				EMS Number				EMS Personnel				EMS Number													
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Not for general distribution.
Exempt from discovery.
(RCW 43.70.510)

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Are you First EMS Reporting Agency On The Scene?				<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No		Incident Site				City								
<input type="checkbox"/> 3. Not Applicable																		
Patient Name (Last, First, Middle Init.)						Mo.	DOB Day	Yr.	Yrs.	AGE	Mo.	Gender						
												<input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> Unk				
Patient Address						City & State				Phone				Geocode		MCI		
														<div><div></div><div></div></div>		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Nearest Relative Name						Relation				Phone				Resp. in FD		Pt. #	Out Of	
														<div><div></div><div></div></div>		<div><div></div><div></div></div>	<div><div></div><div></div></div>	
Patient Healthcare Provider						Phone				1st Unit on Scene						Resp. from QTRs?		
														<div><div></div><div></div></div>		<input type="checkbox"/> Yes <input type="checkbox"/> No		
ACTION TAKEN				<input type="checkbox"/> 4. Patient Refused Treatment				Mechanism <div><div></div><div></div><div></div><div></div></div> Type <div><div></div><div></div><div></div><div></div></div>		INITIAL DISPATCH CODE		Reporting BLS Unit		<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No				
<input type="checkbox"/> 1. Exam Only				<input type="checkbox"/> 5. Service Aid/Patient Assist						<div><div></div><div></div><div></div><div></div></div>								
<input type="checkbox"/> 2. Exam & Assist				<input type="checkbox"/> 6. Cancelled														
<input type="checkbox"/> 3. No Exam Needed				<input type="checkbox"/> 7. No Patient Found														
Name of Medical Facility Contacted						LOCATION TYPE												
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PROCEDURES		<input type="checkbox"/> 0. None <input type="checkbox"/> 1. Oxygen <input type="checkbox"/> 2. Wound Care <input type="checkbox"/> 3. Extrication/Rescue <input type="checkbox"/> 4. Splinting <input type="checkbox"/> 5. Bag Mask				<input type="checkbox"/> 6. ECG Monitor <input type="checkbox"/> 7. C-Collar/Backboard <input type="checkbox"/> 8. CPR <input type="checkbox"/> 15. Man. DC Shock by EMT <input type="checkbox"/> 21. Auto. DC Shock by EMT <input type="checkbox"/> 25. AED Attached/No Shock				<input type="checkbox"/> 29. Epipen Used								
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										<div><div>2</div><div>1</div><div></div><div></div><div></div><div></div></div>								
										<div><div>2</div><div>5</div><div></div><div></div><div></div><div></div></div>								
TIME DISPATCH NOTIFIED		TIME UNIT NOTIFIED BY DISPATCH		TIME UNIT RESPONDED		TIME ARRIVED ON SCENE		TIME ARRIVED PATIENT'S SIDE		TIME PATIENT LEFT SCENE		ARRIVED AT TREATMENT FACILITY		IN SERVICE				
<div><div></div><div></div><div></div></div>		<div><div></div><div></div><div></div></div>		<div><div></div><div></div><div></div></div>		<div><div></div><div></div><div></div></div>		<div><div></div><div></div><div></div></div>		<div><div></div><div></div><div></div></div>		<div><div></div><div></div><div></div></div>		<div><div></div><div></div><div></div></div>				
CARDIAC ARREST		CPR INITIATED BY				Arrest After Arrival of EMS Personnel?		AED/PAD Used				INITIAL RHYTHM		PATIENT OUTCOME (if known)				
		<input type="checkbox"/> 1. First Responder / Police <input type="checkbox"/> 5. MD / RN				<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No		<input type="checkbox"/> 1. Citizen - no shock <input type="checkbox"/> 2. Citizen - shock <input type="checkbox"/> 3. First Responder - no shock <input type="checkbox"/> 4. First Responder - shock				<input type="checkbox"/> 2. V Fib <input type="checkbox"/> 4. Asystole <input type="checkbox"/> 7. Other <input type="checkbox"/> 8. Unknown		<input type="checkbox"/> 1. DOA <input type="checkbox"/> 2. Expired at scene <input type="checkbox"/> 3. Admitted to ER <input type="checkbox"/> 4. Expired at ER <input type="checkbox"/> 5. Admitted to Hospital <input type="checkbox"/> 6. Unknown				
		<input type="checkbox"/> 2. Fire Dept. (BLS) <input type="checkbox"/> 6. Citizen with Dispatch Assistance				Was Cardiac Arrest Witnessed?		ESTIMATED ELAPSED TIME (MIN.) FROM -										
		<input type="checkbox"/> 3. Paramedic (ALS) <input type="checkbox"/> 7. Citizen without Dispatch Assistance				<input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 3. Unk		Collapse to Call Collapse to CPR				<div><div></div><div></div></div>						
		<input type="checkbox"/> 4. Ambulance <input type="checkbox"/> 8. CPR Not Attempted																
Transport Agency Number				Transport Destination				TYPE OF TRANSPORT DELAY										
<div><div></div><div></div><div></div></div>				<div><div></div><div></div></div>				<input type="checkbox"/> 1. None <input type="checkbox"/> 2. Crowd <input type="checkbox"/> 3. Directions <input type="checkbox"/> 4. Distance <input type="checkbox"/> 5. Diversion <input type="checkbox"/> 6. HazMat <input type="checkbox"/> 7. Safety <input type="checkbox"/> 8. Staff Delay <input type="checkbox"/> 9. Traffic <input type="checkbox"/> 10. Vehicle Crash <input type="checkbox"/> 11. Vehicle Failure <input type="checkbox"/> 12. Weather <input type="checkbox"/> 13. Other										
EMS Personnel				EMS Number				EMS Personnel				EMS Number						
<div><div></div><div></div><div></div><div></div><div></div><div></div></div>				<div><div></div><div></div><div></div><div></div><div></div><div></div></div>				<div><div></div><div></div><div></div><div></div><div></div><div></div></div>				<div><div></div><div></div><div></div><div></div><div></div><div></div></div>						
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<div><div></div><div></div><div></div><div></div><div></div><div></div></div>				<div><div></div><div></div><div></div><div></div><div></div><div></div></div>				<div><div></div><div></div><div></div><div></div><div></div><div></div></div>				<div><div></div><div></div><div></div><div></div><div></div><div></div></div>						

Agency Use:

SAFETY EQUIPMENT				EYE OPENING		VERBAL RESPONSE		MOTOR RESPONSE		SUSPECTED ALCOHOL/DRUGS	
<input type="checkbox"/> 1. None	<input type="checkbox"/> 6. Airbag Only	<input type="checkbox"/> 11. Eye Protection		4 <input type="checkbox"/> Spontaneously	5 <input type="checkbox"/> Oriented	6 <input type="checkbox"/> Obeys Commands		<input type="checkbox"/> 1. Yes		<input type="checkbox"/> 2. No	
<input type="checkbox"/> 2. Shoulder Belt	<input type="checkbox"/> 7. Airbag/Lap	<input type="checkbox"/> 12. Protective Clothing/Gear		3 <input type="checkbox"/> To Voice	4 <input type="checkbox"/> Confused	5 <input type="checkbox"/> Locates Pain		<input type="checkbox"/> 1. Yes		<input type="checkbox"/> 2. No	
<input type="checkbox"/> 3. Lap Belt	<input type="checkbox"/> 8. Airbag/Lap/Shoulder	<input type="checkbox"/> 13. Flotation Device		2 <input type="checkbox"/> To Pain	3 <input type="checkbox"/> Inapprop. Words	4 <input type="checkbox"/> W'draw from Pain		<input type="checkbox"/> 1. Yes		<input type="checkbox"/> 2. No	
<input type="checkbox"/> 4. Shoulder/Lap Belt	<input type="checkbox"/> 9. Airbag/Child Seat	<input type="checkbox"/> 88. N/A		1 <input type="checkbox"/> No Response	2 <input type="checkbox"/> Incomprehensible	3 <input type="checkbox"/> Flexion to Pain		<input type="checkbox"/> 1. Yes		<input type="checkbox"/> 2. No	
<input type="checkbox"/> 5. Child Seat	<input type="checkbox"/> 10. Helmet	<input type="checkbox"/> 99. Unknown			1 <input type="checkbox"/> No Response	2 <input type="checkbox"/> Extension to Pain		<input type="checkbox"/> 1. Yes		<input type="checkbox"/> 2. No	
						1 <input type="checkbox"/> No Response		<input type="checkbox"/> 1. Yes		<input type="checkbox"/> 2. No	

FLOW CHART	TIME								Notes		SPHERE
	Blood Pressure										
Pulse Rate											<input type="checkbox"/> Hx
Respiratory Rate											<input type="checkbox"/> Alert Left
ECG Rhythm											Diabetes
Oxygen											<input type="checkbox"/> Hx
Pulse Oximetry											<input type="checkbox"/> Alert Left
Glucometry											CONFIRM
DC Shock											<input type="checkbox"/> Address
											<input type="checkbox"/> Phone #

Medications Taken By Patient At Home <input type="checkbox"/> None	Allergies: <input type="checkbox"/> NKDA

Narrative

